AZ HIPAA Medicaid Consortium

March 12, 2003
2:00 PM to 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:

ADHS	**Lori Petre**	**Pinal LTC**
Janice Hippe	**Frank Straka**	**Susan Murphy**
Susan Ross	**Phyllis Tracy**	**PHS**
Lee Cisney	**Pat Spencer**	**Mark Hart**
Dennis Seidel	**Tom Wood**	**UFC**
Ric Surber	**APIPA**	**Eric Nichols**
Dimiter Peuin	**David Wormell**	**Kathleen Oestreich**
Jerri Gray	**DES**	**John Valentino**
Thomas Browning	**Marcella Gonzalez**	**Verizon**
Jeannette Heller	**Stan Hime**	**Marsha Solomon**
Brian Heise	**Bonnie Ann Smith**	**Yavapai County**
CJ Major	**Major Williams**	**David Soderberg**
AHCCCS	**Nicole Yarborough**	
Brent Ratterree	**HCA**	
Angela Fischer	**Stacy Kruse**	
Terri Greene	**Kathy Thurman**	
Gary Heller	**Mike Uchrin**	
Mary Kay McDaniel	**HCSD**	
John Peters	**Michael Wells**	
Matt Furze	**IHS**	
Dave Walter	**Charolett Melcher**	
Diane Sanders	**MCP & Schaller Anderson**	
David Shelburg	**Anne Romer**	
Kyra Westlake	**Art Schenkman**	
Patti Goodwin	**Cathy Jackson-Smith**	
Kathleen Bezon	**Melanee Jones**	
Deborah Burrell	**NEAZ**	
Bruce Jameson	**Russ Johnson**	
Nancy Mischung		

1. Welcome (Gary Heller)

Welcome to everyone.

2. Format/Frequency/Structure of Meetings

a. Review of Agenda (Gary Heller)

b. Consortium Member Sign-in List (Lori Petre)

A sign in list is coming around.

Action Item: We are trying to clean up the email contacts.

c. Structure (Lori Petre)

This meeting will focus on the 834 and 820. We are trying to take specific transactions as they are ready and focus the majority of the meeting on that specific transaction.

The frequency of the meetings will change primarily in May and June.

Action Item: We will send an email soliciting your interest to see if increasing the frequency of this meeting to possibly every three weeks would be possible.

We will continue to send out information in between meetings.

3. Project Organization (Gary Heller)

Attached is a Project Team Structure Organizational Chart. There are a few people who are no longer working on this project. It is mostly hands on, interactive.

Nancy Mischung has the Mercator mapping team and PMMIS/HPMMIS remediation.

Lori Petre has the Companion Documents, Translator Mapping Specs, Subject Matter Experts and Acceptance Testing.

Tom Walsh has started Contingency Planning, covering the "what ifs". We are flushing out a contingency plan for each scenario.

Dave Walter has started Implementation Planning

Ryan Wieler is Project Manager of our Mercator team

Sandy Biggs is covering HCG/PSP systems

Angela Fischer is our HIPAA coordinator.

4. Project Schedule (Gary Heller)

The Project Milestones attachment was discussed:

Group 1:

Analysis, Requirements and System Design are Complete.

820/834; 270/271 Companion Documents are On schedule for 03/21/03.

System Development is in progress. The project managers are building project schedules, tying resources.

This defers from the Web site published dates that were moved out about a week and a half. You will notice that the Pilot testing and Trading Partner testing activities have not moved. We are committed to making those dates.

Group 2:

Analysis is Complete.

Requirements and System Design are In Progress.

Companion Documents are in progress for the 837.

System Development is also in progress.

As you can see we are increasing resources to try and stay on schedule.

5. Companion Documents/Trading Partner

Referenced in above conversation.

6. Testing Update (Lori Petre)

We are working on finalizing a draft Test Plan by the 21st. We are finalizing the look and data content of our test environment.
We are finalizing our approach to our Group 1 testing.

Action Item: An email will be sent notifying you of what we have in mind for our approach. If you have any additional suggestions they are welcome.

We are working on identifying the testing approach for Group 2 as well.
We are identifying who needs to be involved in the testing and at what level. Who are the points of contact, etc.
We are looking at testing not only if the changes we (ISD) make work, but do they work for you as the customer.
It will be broad effort as a result.

We need the surveys that went out back by the 21st, please. The purpose of the follow up survey was to confirm first the data that has been already sent and to get the primary and secondary contacts for testing.

We are also working on sending surveys for the FFS providers that involve testing.

We are aiming for final validation of our test environment for the 1st of April.

Q: Is it possible to get a representative test file before we go into a full-scale test?
A: We can look at doing this out of our system and integration testing, and providing one for the Group 1 transactions by end of April and then at the end of May for Group 2.

Action Item: A representative test file, out of our system and integration testing would be logical. We will provide one for the Group 1 transactions by end of April and then at the end of May for Group 2.

Q: How soon can we get the specs, we do not want to use the VPN client. We want to tie to your FTP module.
A: Network is whom we would need to talk to after the meeting.

7. Transaction Strategies Update (Lori Petre)

There have been a lot of questions of Transaction strategies.
Action Item: There will be information published within the next few weeks, such as, what has happened in our translator versus what we need to do in our remediation.
We will continue to publish these items between the meetings and not hold this data until the next meeting.

8. Detailed Discussion/Presentation of AHCCCS 834/820 Transactions (Mary Kay McDaniel)

We are attempting to work from the processes of today to what we envision it to be.
We have documentation that was provided from workgroup meetings. We started asking questions such as “Is everything being sent every time?”, and the answer was to be found in our mapping documents. Therefore, assumptions have been made from the health plans perspective, which we will need confirmation from you today whether these assumptions/expectations are correct.

We are currently working very hard on the specs and need to hand them over to the mappers.

We want to start with the differences.

We are not going to maintain the same process flow as what exists in PMMIS. The process of building a roster will no longer be done at AHCCCS. All the preliminary work will flow into building files for the translator.
There is a Prior Plan file, TPL file, FYI file, and the Roster itself.

Health Plans will receive an 834 with only enrollment information.
Some TPL information will be available on the roster, but Health Plans will receive a TPL file separately since it contains information that could not be placed on the 834.
The Prior plan file had only one piece of information that was not on the roster Health Plans were receiving, the "health plan name". The Health Plan Name has been added to the 834, the Prior Plan File will be discontinued.
The FYI file, which contains CRS Ids, TSC Ids and MHMO information will be on the 834, the FYI file as it exists today will be discontinued.

The Business rules have not changed. If you received a rate code for a particular reason, you will still receive that rate code for that reason. Only the format has been changed.

Highlighting Items in the Handout "Changes and Examples for AHCCCS 834 Enrollment and 820 Capitation Transactions"

834 Enrollment Transactions:
Capitation payment information is not contained within the 834. Changes to enrollment information, only a minimum dataset will be sent.
Today everything is sent even if only the address has been changed.
We map it currently on the 834 as only receiving the changed item, such as address, name change.

There are currently eight slots for changes on one record now. With the 834, Health Plans will receive a record for every change.

Marital status and language codes have been added or. These elements will only be sent Adds.

Share of Costs (SOC) the six most recent will be available as Adds.

Processing Change. If there are no changes to enrollment records a blank 834 cannot be produced indicating "there are no enrollment changes".

820 Capitation Transaction

The 820 for AZ will be both the Organization Summary and the Individual.
The Organizational will exist only if there are sanctions or negotiated settlements.
The Behavioral Health will only contain the Organizational summary.

834 and 820 Examples

The elements that are not going to change are not included.

The Specs will be available if you would like to see them once they are finalized. Just let us know.

Q: Did you get a chart of the Code Set mapping?
A: From a long time ago.

Action Item: A new copy of the Code Sets will be updated in the new companion documents and placed on the web site.

The Action code mapping and type will be used to drive what will happen in Mercator. We will bluff Mercator into becoming a line item translator. The way we receive records today are sorted by a

member id, which is not going to change. We will have a sequence number that we will need to watch for in the testing to get the sequence correct.

We need to get all the translator specs together. We will be building a table from the tax ID. If you have a tax ID that AHCCCS does not have, please advise today.

Transaction 1
2000 Member Level

The 2000 Member detail level:
Insured Indicator will always be a 'Y' and Relationship Code an '18'.
For an Add action type, any action code you will receive a maintenance type of 021.
The maintenance reason will change. There is a code set mapping for existing and HIPAA reason codes have translated.
If the Action Codes are 'AA' and 'EC' will appear on the 2300 loop. These have not hit the 4050 version. We are looking at some time before they are available, therefore we will add at the 2300 loop.
Benefit Status code will always be an "A".
Medicare Plan code will change as the member's info changes.
AHCCCS ID number will show as a Ref02.
Supplementary Id includes Case ID, Primary AHCCCS ID, Med CLM ID

Action Item: If we need and we can all agree the voucher number could be placed here as well.
Result: The voucher number has been added to the 834 transaction.

Date and Time Qualifier:
There were two date and time qualifiers appropriate for Medicaid business. The Medicaid begin and end date and the Eligibility begin and end date.
The mapping group chose the Eligibility begin and end with the concern that it wasn't really a Medicaid begin and end date, the dates where very different. Therefore they chose a 356/357.
Status Info Effective Date can be an Enroll begin or end date.

The fields on your current roster are to the right so your mappers can see where we are moving the data.

2100A Member Loop

For an Add it will always be an 'IL'
Last name, First name, MI as it appears
SSN
Residence phone number
Emergency phone number is there today, may not have been there before.
Address, etc.

2100 C Member Mailing Address

Anytime an address is sent you will receive a 2100C.
We currently do not have a way to decide if this address is different from the first. (A difference of just a period could exist). Therefore you will receive this address as well.

2200 Disability Information

Disability information will appear for those members who are pregnant, diagnosis code 'V22'.

The pregnancy is definitely needed by the plans and will continue to have the same issues that once you have it you will always have it. A change of the pregnancy will not be received. That is how it currently exists today.

2300 Health Coverage

One of the things we have determined is that you only need the TPL coverage once.

There will be a maximum of 5 loops since you will have separate TPL file.

The maintenance type code for an Add '021'
The Ins Line Code 'HMO'
Plan Coverage Desc will be the rate code, prior plan id, prior plan name, Action codes AA or EC all other blank.
Date/Time Qualifier is the Benefits begin.
Coverage period is Enroll from date with the contract type.

In addition would be whatever TPL information they have at a minimal amount.
The max number of COB loops will only appear under the receiving plan 2300 loop.

If the individual has Mental Health coverage there will be a second loop with:
Maintenance Type '021'
Ins Line Cd 'AK'
Mental Health Category code.
Etc.

If a LTC facility is involved:
Maintenance Type '021'
Ins Line Cd 'FAC'.
Etc.

The LTC transition indicator will be in the first position, provider id in the next six, and provider name 25.
Which means that first byte will be blank if they are not in transition.

Q: Does anyone's translator have a problem with that?
A: No.

The 2300 SOC loop.
Maintenance type code of an Add.
Ins Line Code 'LTC'
No plan coverage description.
SOC contract amount with the latest six.

The next three loops is general information that comes off the FYI file.
PRA will indicate the CRS client
CRS ID
348 Benefits Begin Date or process date.

Q: Do you have any preferences on that code on an Add.
A: It allows four days. The begin and end date are received today. We would like both.

An open-end date cannot be sent.

Assumption if there is no end date it will be open ended.

Action Item: Mary Kay will look at this date file.
Result: Done. See the companion guides.

Medicare HOMO ID and Name, PRA is also going to be used for the client.
The same Insurance Line code is being used for CRS, TSC and HP-FYI.

Q: How will the plans know if it is an CRS, TSC or HMO?

Action Item: We will need to look at this to be able to tell you how to differentiate from each. When we send the minutes this information will be sent as well.
Result: Done. See the updated companion guides and the examples that will be on the web site next week.

Transaction 2:
Disenroll:

We envision it as the Action taking place at the 2000 level and below. The 1000A and 1000B will be the same.

Member Level Detail:
Maintenance type code 024 (termination)
An action will be built based upon the crosswalk.
Benefit Status 'A'
Medicare plan code will be an 'E'
If the insured has a DOD it will be there, if not blank.
AHCCCS ID, Date/Time Qualifier, Enrollment end date, etc.

We will send the name, SSN, DOB, gender for tracking purposes.

The 2300 loop will basically say HMO.

If TPL info exists it will be sent.

Transaction 3:
Block Enroll, no TPL:

For the difference between a regular enroll and block enroll is the same with an effective and end date both on a 2000 and at the 2300, health coverage.

Transaction 4:
Block Disenroll:

A block disenroll you will have a maintenance type of disenroll and appropriate translated values.

Transaction 5:
Address change:

Action type 'C' and 'AC'
Maintenance type 01 for a change
Maintenance reason code will be translated.
Medicare plan code will be translated.
The Date/Time qualifier will be a 303 to the maintenance.
The member name will be displayed.
The residence phone number.
Address changes also indicate phone number changes.
Again you will receive both addresses.

The 2300 health coverage loop will only be there if there is TPL information.
If none you will not receive the 2300 loop.
Maintenance type code 030.

Transaction 6:
DOB Change and/or Gender Correction and/or Name Change:

Some of these fields were required for both changes, it is difficult to display what was changed.
The Maintenance type code 'C'
The Maintenance type code '001'

You may want to look at this closely since you will only get an AHCCCS ID, no SSN, Alt ID, etc.

2100A will have a Identifier 74
2100B will have a Identifier 70.

You will need to perform comparisons.
We could not send the DOB without the Gender.

If a TPL record is present you will have a 2300 loop. This is for compare only.

Transaction 7:
Mental Health Change:

The way the Maintenance reason is set up right now is blank.
AHCCCS ID, Name and the 2300 loop that you receive will only be mental health 2300 loop.
There is no process for a category or date change.

If there were TPL, the TPL will follow the 2300 loop. An additional HMO loop will not be added.

Transaction 8:
Pregnancy Indicator Change:

The 2000 loop information is listed as described in others, you receive the member name and disability information 'V22'.

Transaction 9:
Rate Code Change:

A full layout was preferred.
The only change that you will receive that has everything will be a rate code change.
Maintenance reason '29'
If you chose to compare all the data sent it is your choice.
A 2300 loop will be present indicating the change of the new rate code.
If TPL exists it will be there.

Transaction 10:
SOC Change:

The minimal 2000 information.
SOC will have an effective coverage period.

Transaction 11:
Mental Health Termination:

Is the same as the Mental Health section.

No Maintenance reason code will be given.

Transaction 12:
TPL with no Roster Information:

One of the situations that we will run up against today that we do not have today is:

When merging TPL information into the file that is fed into the computer for translation, there can be situations were TPL exists without a roster.
We will then send an 834 indicating the TPL change.
Maintenance Type 001
Maintenance reason 33, which will only be used in this situation.

The TPL information will be available.

Transaction 13:
Disenroll "Deceased":

A disenroll with a 'DE'
The insured's DOD will be included.

Q: The 2000 member level detail is currently using a maintenance code of a 303, would you prefer to have a 339 end date and enroll end date at this level in addition to having it at the 2300 level?
A: No

Transaction 14:
TPL with No Roster Information:

Medicare flag changed because of the change to the TPL.

Transaction 15:
Monthly Audit Transaction:

It will look similar to the Add transactions.
All the information on the member and TPL if they have it.
You will receive Elig end date plus all of the 2300 loops.

Q: On YO2, are the 639 language code sets being used, 2-character or 3 in language code?
A: We would use 3-character, upper case.

Q: Can transactions be sent all uppercase or all lower case? Is there a preference?
A: Uppercase allows everything to come through.

Element deliminator will not include an *. The carrot will be element separator. The pipe will be the composite separator. The segment terminations will be the tildi.

Q: Custodial parent information is it available to populate? This helps verify that this person is the actual guardian, not received today but a spot on the 834 is available were we could populate it.
A: No discussion has been put on the table to populate this. It is not on the mapping that we are doing.

Action Item: Follow up for Custodial parent information will be made.

We will have updates of these discussions and publish with minutes.

820 Weekly Capitation Payment – Medical

Capitation payment for Medical or everyone who gets an individual capitation payment or in a lump sum positive or negative payment:

For Health plans the 2000 a will not be seen a lot, but is mapped in case it is used.

The 2300a will include a rough qualifier, and rough qualifier Id.
Z122 , the total payment amount will be associated.

The individual remittance advice:
The id qualifier will have a zz
2300 rough id qualifier will have insured remit reference number. It will have contract type and will always use PI as a payment whether negative or positive.

Payment from or through as you see today on your roster.

Next PG is for a 2nd member and how would it look.

820 Weekly Capitation Payment – BHS

This information is layed out, we are looking at a particular report that breaks it down by Native American, etc.
After the meeting you can tell me what you want this to be.

9. Wrap-up – Questions

Clean Up Items:
We have gathered everything we could about the 834 and have a few items needing follow up.

- There is a request to set up the 834 transaction so that multiple segments of rate code and contract type and effective date are transmitted in date order.

  This does not work since it takes it out of sequence. The enrollment gets out of sync.

  The 820 will be rolled out by ID number.

- Another request asked for a separate ST/SE by member.

  This is possible to do, but we need a reason why someone would need this. Would you really want to manage 100,000, 50,000, 30,000 - 997's?
  Everyone shook his or her heads that this was not necessary.

- The Implementation Guide suggests we break the ST/SE files by 10,000. Do any of you have a preference? All in one? By 5,000? Etc.

  1,000 is good. Everyone agreed.
  The problem with the 820 is that you cannot break it with the ST/SE. If you have a name change that did not have dollars affected you will not get this transaction.
  Therefore a one to one match could not happen between your 834 and 820.

  Action Item:
  Suggestion: Put this in the project plan for post implementation, and look at it on an incremental basis, to see if the 1,000 number should increase.

Result: Done. The initial 834 transactions will be set at increments of 1000. The issue to review post-implementation has been included in the implementation document.

Last question is in reference to balancing. From an AHCCCS perspective there is a separate file put out, if a voucher number does not come across on 834 and only on 820, do you have a way to balance that out?
We could add this if you are all willing, there is reporting category 17- client reporting.
This seems it would allow us to add a voucher record on the 834, which would give a list of vouchers that should be on your weekly payment.
Agreement overall, voucher as 17 on every transaction dealt with dollars.

3H case id, f6 medical claim id.

Action Codes Handout:

These are all of the current AHCCCS action codes, with description on type of action, and what it has been translated into on the 834 side.

Some codes you may never see since they are behind the scenes. You have an Add action, Change action, and Delete action.

The items that have the note: "820 transaction – no map for 834", will not be received when sent on the 834.

Action Codes Translation Rules Handout:

This document is a handy dandy tool for your use.

We tried to lay this out by actual field from the roster.

Questions

Q: FYI files for the two missing action codes?
Are there any specs?

A: For the AA and EA, a request was sent, they did not make it for the 4050 and are being looked at the 4060. Which means we will not see these for a couple of years. Maybe 2006.

Q: When can we expect a dummy file?

A: End of April.

New approach to our Companion Documents (John Peters):

Two parts of the companion docs.

They are the external portion of what Mary Kay covered. The companion docs are what you will receive and some of the procedures you will have to go through.

We talk about transactions, testing conventions.

In the Trading Partner agreements we get specific about each data element that AHCCCS uses in a special way.

They are much more heavily focused on AHCCCS.

We now have one for Encounter under review and will be used as a base.

A draft was released for HI.

Our original approach was repeating the Implementation Guide, these documents have now been refocused. This one is not as large and will be more manageable. Basic idea is specific information to this AHCCCS interface.

This does not take the place of the contracts/ agreements that you sign. It only outlines them.

Next meeting is April 9th, same time.

We will try to send out the agenda two weeks ahead of time.

Will hope to talk about 837 next. And revisit 834 as necessary. The minutes will be out within the next week or so, so you can provide any feedback.

Questions submit to web site, please. (It is the best place for tracking purposes)
Meeting adjourned.